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APPENDIX C

RESIDENT ASSESSMENT PROTOCOLS

Numeric Identifier _____

SECTION V. RESIDENT ASSESSMENT PROTOCOL SUMMARY

Resident's Name: _____		Medical Record No.: _____	
<p>1. Check if RAP is triggered.</p> <p>2. For each triggered RAP, use the RAP guidelines to identify areas needing further assessment. Document relevant assessment information regarding the resident's status.</p> <ul style="list-style-type: none"> • Describe: <ul style="list-style-type: none"> — Nature of the condition (may include presence or lack of objective data and subjective complaints). — Complications and risk factors that affect your decision to proceed to care planning. — Factors that must be considered in developing individualized care plan interventions. — Need for referrals/further evaluation by appropriate health professionals. • Documentation should support your decision-making regarding whether or not to proceed with a care plan for a triggered RAP and the type(s) of care plan intervention(s) that are appropriate for a particular resident. • Documentation may appear anywhere in the clinical record (e.g., progress notes, consults, flow sheets, etc.). <p>3. Indicate under the <u>Location of RAP Assessment Documentation</u> column where information related to the RAP assessment can be found.</p> <p>4. For each triggered RAP, indicate whether or not a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment. The Care Planning Decision column must be completed within 7 days of completing the RAI (MDS and RAPs).</p>			
A. RAP PROBLEM AREA	(a) Check if triggered	Location and Date of RAP Assessment Documentation	(b) Care Planning Decision—check if addressed in care plan
1. DELIRIUM	<input type="checkbox"/>		<input type="checkbox"/>
2. COGNITIVE LOSS	<input type="checkbox"/>		<input type="checkbox"/>
3. VISUAL FUNCTION	<input type="checkbox"/>		<input type="checkbox"/>
4. COMMUNICATION	<input type="checkbox"/>		<input type="checkbox"/>
5. ADL FUNCTIONAL/REHABILITATION POTENTIAL	<input type="checkbox"/>		<input type="checkbox"/>
6. URINARY INCONTINENCE AND INDWELLING CATHETER	<input type="checkbox"/>		<input type="checkbox"/>
7. PSYCHOSOCIAL WELL-BEING	<input type="checkbox"/>		<input type="checkbox"/>
8. MOOD STATE	<input type="checkbox"/>		<input type="checkbox"/>
9. BEHAVIORAL SYMPTOMS	<input type="checkbox"/>		<input type="checkbox"/>
10. ACTIVITIES	<input type="checkbox"/>		<input type="checkbox"/>
11. FALLS	<input type="checkbox"/>		<input type="checkbox"/>
12. NUTRITIONAL STATUS	<input type="checkbox"/>		<input type="checkbox"/>
13. FEEDING TUBES	<input type="checkbox"/>		<input type="checkbox"/>
14. DEHYDRATION/FLUID MAINTENANCE	<input type="checkbox"/>		<input type="checkbox"/>
15. DENTAL CARE	<input type="checkbox"/>		<input type="checkbox"/>
16. PRESSURE ULCERS	<input type="checkbox"/>		<input type="checkbox"/>
17. PSYCHOTROPIC DRUG USE	<input type="checkbox"/>		<input type="checkbox"/>
18. PHYSICAL RESTRAINTS	<input type="checkbox"/>		<input type="checkbox"/>

B. _____

1. Signature of RN Coordinator for RAP Assessment Process

3. Signature of Person Completing Care Planning Decision

2.

Month	Day

Year			

4.

Month	Day

Year			

RESIDENT ASSESSMENT PROTOCOL TRIGGER LEGEND FOR REVISED RAPs (for MDS Version 2.0)

Key:																						
● = One item required to trigger																						
● = Two items required to trigger																						
* = One of these three items, plus at least one other item required to trigger																						
ⓐ = When both ADL triggers present, maintenance takes precedence																						
<u>Proceed to RAP Review once triggered</u>																						
MDS ITEM		CODE	Delirium	Cognitive Loss/Dementia	Visual Function	Communication	ADL-Rehabilitation Trigger A ⓐ	ADL-Maintenance Trigger B ⓐ	Urinary Incontinence and Indwelling Catheter	Psychosocial Well-Being	Mood State	Behavioral Symptoms	Activities Trigger A	Activities Trigger B	Falls	Nutritional Status	Feeding Tubes	Dehydration/Fluid Maintenance	Dental Care	Pressure Ulcers	Psychotropic Drug Use	Physical Restraints
B2a	Short-term memory	1	●																			B2a
		1	●																			B2b
B4	Decision-making	1,2,3	●																			B4
B4	Decision-making	3					●															B4
B5a-B5f	Indicators of Delirium	2	●																	●		B5a-B5f
B6	Change in Cognitive Status	2	●																	●		B6
C1	Hearing	1,2,3			●																	C1
C4	Understood by others	1,2,3			●																	C4
C6	Understand others	1,2,3	●		●																	C6
C7	Change in communication	2																		●		C7
D1	Vision	1,2,3		●																		D1
D2a	Side vision problem	✓		●																		D2a
E1a-E1p	Indicators of depression, anxiety, sad mood	1,2								●												E1a-E1p
E1n	Repetitive movement	1,2																		●		E1n
E1o	Withdrawal from activities	1,2							●													E1o
E2	Mood persistence	1,2								●												E2
E3	Change in mood	2	●																	●		E3
E4aA	Wandering	1,2,3													●							E4aA
E4aA-E4eA	Behavioral symptoms	1,2,3									●											E4aA-E4eA
E5	Change in behavioral symptoms	1									●											E5
E5	Change in behavioral symptoms	2	●																	●		E5
F1d	Establishes own goals	✓							●													F1d
F2a-F2d	Unsettled relationships	✓							●													F2a-F2d
F3a	Strong ID, past roles	✓							●													F3a
F3b	Lost roles	✓							●													F3b
F3c	Daily routine different	✓							●													F3c
G1aA-G1jA	ADL self-performance	1,2,3,4				●																G1aA-G1jA
G1aA	Bed mobility	2,3,4,8																	●			G1aA
G2A	Bathing	1,2,3,4				●																G2A
	Balance while sitting	1,2,3																		●		G3b
G6a	Bedfast	✓																	●			G6a
G8a,b	Resident, staff believe capable	✓				●																G8a,b
H1a	Bowel incontinence	1,2,3,4																	●			H1a
H1b	Bladder incontinence	2,3,4						●														H1b
H2b	Constipation	✓																		●		H2b
H2d	Fecal impaction	✓																		●		H2d
H3c,d,e	Catheter use	✓						●														H3c,d,e
H3g	Use of pads/briefs	✓						●														H3g
I1i	Hypotension	✓																		●		I1i
I1j	Peripheral vascular disease	✓																	●			I1j
I1ee	Depression	✓																		●		I1ee
I1jj	Cataracts	✓		●																		I1jj
I1ll	Glaucoma	✓		●																		I1ll
I2j	UTI	✓															●					I2j
I3	Dehydration diagnosis	276.5															●					I3
J1a	Weight fluctuation	✓															●					J1a
J1c	Dehydrated	✓															●					J1c
J1d	Insufficient fluid	✓															●					J1d
J1f	Dizziness	✓												●						●		J1f
J1h	Fever	✓															●					J1h
J1i	Hallucinations	✓																		●		J1i
J1j	Internal bleeding	✓															●					J1j
J1k	Lung aspirations	✓																		●		J1k

[illegible]

1. RESIDENT ASSESSMENT PROTOCOL: DELIRIUM

I. PROBLEM

Delirium (often referred to in the past as an acute confusional state) is a common indicator or nonspecific symptom of a variety of acute, treatable illnesses. It is a medical emergency, with high rates of morbidity and mortality, unless it is recognized and treated appropriately. Delirium is never a part of normal aging. Some of the classic signs of delirium may be difficult to recognize and may be mistaken for the natural progression of dementia, particularly in the late stages of dementia when delirium has high mortality. Thus careful observation of the resident's inattentiveness and review of potential causes is essential.

Delirium is characterized by fluctuating states of consciousness, disorientation, decreased environmental awareness, and behavioral changes. The onset of delirium may vary, depending on severity of the cause(s) and the resident's health status; however, it usually develops rapidly, over a few days or even hours. Even with successful treatment of cause(s) and associated symptoms, it may take several weeks before cognitive abilities return to pre-delirium status.

Successful management depends on accurate identification of the clinical picture, correct diagnosis of specific cause(s), and prompt nursing and medical intervention. Delirium is often caused and aggravated by multiple factors. Thus, if you identify and address one cause, but delirium continues, you should continue to review the other major causes of delirium and treat any that are found.

II. TRIGGERS

Delirium problem suggested if one or more of following present:

- Easily Distracted^(a)
[B5a = 2]
- Periods of Altered Perception or Awareness of Surroundings^(a)
[B5b = 2]
- Episodes of Disorganized Speech^(a)
[B5c = 2]
- Periods of Restlessness^(a)
[B5d = 2]
- Periods of Lethargy^(a)
[B5e = 2]
- Mental Function Varies Over the Course of the Day^(a)
[B5f = 2]
- Cognitive Decline^(a)
[B6 = 2]
- Mood Decline^(a)
[E3 = 2]
- Behavior Decline^(a)
[E5 = 2]

^(a) **Note:** All of these items also trigger on the Psychotropic Drug Use RAP (when psychotropic drug use present).

III. GUIDELINES

Detecting signs and symptoms of delirium requires careful observation. Knowledge of a person's baseline cognitive abilities facilitates evaluation.

- Staff should become familiar with resident's cognitive function by regularly observing the resident in a variety of situations so that even subtle but important changes can be recognized.

When observed in this manner, the presence of any trigger signs/symptoms may be seen as a potential marker for acute, treatable illness.

An approach to detection and treatment of the problem can be selected by reviewing the items that follow in the order presented. Also refer to the RAP KEY for guidance on the MDS items that are relevant.

DIAGNOSES AND CONDITIONS

By correctly identifying the underlying cause(s) of delirium, you may prevent a cycle of worsening symptoms (e.g., an infection-fever-dehydration-confusion syndrome) or a drug regimen for a suspected cause that worsens the condition. The most common causes of delirium are associated with circulatory, respiratory, infectious, and metabolic disorders. However, finding one cause or disorder does not rule out the possibility of additional contributing causes and/or multiple interrelated factors.

MEDICATIONS

Many medications given alone or in combination can cause delirium.

- If necessary, check doctor's order against med sheet and drug labels to avoid the common problem of medication error.
- Review the resident's drug profile with a physician.
- Review all medications (regularly prescribed, PRN, and "over-the-counter" drugs).

Number of Medications. The greater the number, the greater the possibility of adverse drug reaction/toxicity.

- Review meds to determine need and benefit (ask if resident is receiving more than one class of a drug to treat a condition).
- Check to determine whether nonpharmacological interventions have been considered (e.g., a behavior management program, rather than antipsychotics, to address the needs of a resident who has physically or verbally abusive behavioral symptoms).

New Medications

- Review to determine whether or not there is a temporal relationship between onset or worsening of delirium and start of new medication.

Drugs that Cause Delirium

1. PSYCHOTROPIC
 - Antipsychotics
 - Antianxiety/hypnotics
 - Antidepressants
2. CARDIAC
 - Digitalis glycosides (Digoxin)
 - Antiarrhythmics, such as quinidine, procainamide (Pronestyl), and disopyramide (Norpace)
 - Calcium channel blockers, such as verapamil (Isoptin), Nifedipine (Procardia), and Diltiazem (Cardizem)
 - Antihypertensives, such as methyldopa (Aldomet), and propranolol (Inderal)
3. GASTROINTESTINAL
 - H2 antagonists, such as cimetidine (Tagamet) and ranitidine (Zantac)
4. ANALGESICS such as Darvon, narcotics (e.g., morphine, dilaudid)
5. ANTI-INFLAMMATORY
 - Corticosteroids, such as prednisone
 - Nonsteroidal anti-inflammatory agents, such as ibuprofen (Motrin)
6. OVER-THE-COUNTER DRUGS, especially those with anticholinergic properties
 - Cold remedies (antihistamines, pseudoephedrine)
 - Sedatives (antihistamines, e.g., Benadryl)
 - Stay-awakes (caffeine)
 - Antinauseants
 - Alcohol

PSYCHOSOCIAL

After serious illness and drug toxicity are ruled out as causes of delirium, consider the possibility that the resident is experiencing psychosocial distress that may produce signs of delirium.

Isolation

- Has the resident been away from people, objects and situations?
- Is resident confused about time, place, and meaning?
- Has the resident been in bed or in an isolated area while recuperating from an illness or receiving a treatment?

Recent Loss of Family/Friend. Loss of someone close can precipitate a grief reaction that presents as acute confusion, especially if the person provided safety and structure for a demented resident.

- Review the MDS to determine whether or not the resident has experienced a recent loss of a close family member/friend.

Depression/Sad or Anxious Mood. Mood states can lead to confusional states that resolve with appropriate treatment.

- Review the MDS to determine whether the resident exhibits any signs or symptoms of sad or anxious mood, or has a diagnosis of a psychiatric illness.

Restraints. Restraints often aggravate the conditions staff are trying to treat (e.g., confusion, agitation, wandering).

- Did the resident become more agitated and confused with their use?

Recent Relocation

- Has the resident recently been admitted to a new environment (new room, unit, facility)?
- Was there an orientation program that provided a calm, gentle approach with reminders and structure to help the new resident settle into the environment?

SENSORY LOSSES

Sensory impairments often produce signs of confusion and disorientation, as well as behavior changes. This is especially true of residents with early signs of dementia. They can also aggravate a confusional state by impairing the resident's ability to accurately perceive or cope with environmental stimuli (e.g., loud noises; onset of evening). This can lead to the resident experiencing hallucinations/delusions and misinterpreting noises and images.

Hearing

- Is hearing deficit related to easily remedied situations - impacted ear wax or hearing aid dysfunction?
- Has sensory deprivation led to confusion?
- Has physician input been sought?

Vision

- Has vision loss created sensory deprivation resulting in confusion?
- Have major changes occurred in visual function without the resident's being referred to a physician?

CLARIFYING INFORMATION

- Does the resident have a recent sleep disturbance?
- Does the resident have Alzheimer's or other dementia?

- Has the time of onset of the resident's cognitive and behavioral function been within the last few hours to days?

ENVIRONMENT

- Is the resident's environment conducive to reducing symptoms (e.g., quiet, well-lit, calm, familiar objects present)?
- Is the resident's daily routine broken down into smaller tasks (task segmentation) to help him/her cope?

1. DELIRIUM RAP KEY

(For MDS Version 2.0)

TRIGGER – REVISION	GUIDELINES
<p><i>Delirium problem suggested if one or more of following present:</i></p> <ul style="list-style-type: none"> • Easily Distracted^(a) [B5a = 2] • Periods of Altered Perception or Awareness [B5b = 2] • Episodes of Disorganized Speech^(a) [B5c = 2] • Periods of Restlessness^(a) [B5d = 2] • Periods of Lethargy^(a) [B5e = 2] • Mental Function Varies Over the Course of the Day^(a) [B5f = 2] • Deterioration in Cognitive Status^(a) [B6 = 2] • Deterioration in Mood^(a) [E3 = 2] • Deterioration in Behavioral Symptoms^(a) [E5 = 2] 	<p><i>Factors that may be associated with signs and symptoms of delirium:</i></p> <ul style="list-style-type: none"> • Diagnoses and Conditions – Diabetes [I1a], Hyperthyroidism [I1b], Hypothyroidism [I1c], Cardiac Dysrhythmias [I1e], CHF [I1f], CVA [I1t], TIA [I1bb], Asthma [I1hh], Emphysema/COPD [I1ii], Anemia [I1oo], Cancer [I1pp], Dehydration [J1c] or Fever [J1h], Myocardial Infarction [I3], any Viral or Bacterial Infection [I2], Surgical Abdomen [I3], Head Trauma [I3], Hypothermia [I3], Hypoglycemia [I3]. • Medications – Number of Meds [O1], New Meds [O2], Antipsychotics [O4a], Antianxiety [O4b], Hypnotics [O4d], Analgesics (Pain Meds), Cardiac Meds, GI Meds, Anti-inflammatory, Anticholinergics, [from med charts]. • Psychosocial – Sad or Anxious Mood [E1, E2, E3], Isolation [F2e; from record], Recent Loss [F2f], Depression [I1ee], Restraints [P4c,d,e], Recent Relocation [AB1; A4a]. • Sensory Impairment – Hearing [C1], Vision [D1]. <p><i>Clarifying information to be considered in establishing a diagnosis:</i> Sleep disturbance [E1k], Alzheimer's [I1q], Other Dementia [I1u], Time of symptom onset within hours to days [from record or observation];</p> <p><i>Environment conducive to reducing symptoms:</i> Quiet, well-lit, calm, familiar objects [from observation]; Task segmentation [G7].</p>

^(a) **Note:** All of these items also trigger on the Psychotropic Drug Use RAP (when psychotropic drug use is present).

2. RESIDENT ASSESSMENT PROTOCOL: COGNITIVE LOSS/DEMENTIA

I. PROBLEM

Many residents in nursing facilities exhibit signs and symptoms of decline in intellectual functioning. Recovery will be possible for few of these residents, for example, those with a reversible condition such as an acute confusional state (delirium). For most residents, however, the syndrome of cognitive loss or dementia is chronic and progressive, and appropriate care focuses on enhancing quality of life, sustaining functional capacities, minimizing decline, and preserving dignity.

Confusion and/or behavioral disturbances present the primary complicating care factors. Identifying and treating acute confusion and behavior problems can facilitate assessment of how chronic cognitive deficits affect the life of the resident.

For residents with chronic cognitive deficits, a therapeutic environment is supportive rather than curative and is an environment in which licensed and nonlicensed care staff are encouraged (and trained) to comprehend a resident's experience of cognitive loss. With this insight, staff can develop care plans focused on three main goals: (1) to provide positive experiences for the resident (e.g., enjoyable activities) that do not involve overly demanding tasks and stress; (2) to define appropriate support roles for each staff member involved in a resident's care; and (3) to lay the foundation for reasonable staff and family expectations concerning a resident's capacities and needs.

II. TRIGGERS

A cognitive loss/dementia problem suggested if one or more of following are present:

- Short-term Memory Problem
[B2a = 1]
- Long-term Memory Problem
[B2b = 1]
- Impaired Decision-Making^(a)
[B4 = 1, 2, 3]
- Problem Understanding Others^(b)
[C6 = 1, 2, or 3]

^(a) **Note:** These codes also trigger on the Communication RAP.

^(b) **Note:** Code 3 also triggers on the ADL (Maintenance) RAP.

III. GUIDELINES

Review the following MDS items to investigate possible links between these factors and the resident's cognitive loss and quality of life. The four triggers identify residents with differing levels of cognitive loss. Even for those who are most highly impaired, the RAP seeks to help identify areas in which staff intervention might be useful. Refer to the RAP KEY for specific MDS and other specific issues to consider.

NEUROLOGICAL

Fluctuating Cognitive Signs and Symptoms/Neurological Status - Co-existing delirium and progressive cognitive loss can result in erroneous impressions concerning the nature of the resident's chronic limitations. Only when acute confusion and behavioral disturbances are treated, or when the treatment effort is judged to be as effective as possible, can a true measure of chronic cognitive deficits be obtained.

Recent Changes in the Signs/Symptoms of the Dementia Process - Identifying these changes can heighten staff awareness of the nature of the resident's cognitive and functional limitations. This knowledge can assist staff in developing reasonable expectations of the resident's capabilities and in designing programs to enhance the resident's quality of life. This knowledge can also challenge staff to identify potentially reversible causes for recent losses in cognitive status.

Mental Retardation, Alzheimer's Disease, and Other Adult-Onset Dementias - The most prevalent neurological diagnoses for cognitively impaired residents are Alzheimer's disease and multi-infarct dementia. But increasing numbers of mentally retarded residents are in nursing facilities, and many adults suffering from Down's syndrome appear to develop dementia as they age. The diagnostic distinctions among these groups can be useful in reminding staff of the types of long-term intellectual reserves that are available to these residents.

MOOD/BEHAVIOR

Specific treatments for behavioral distress, as well as treatments for delirium, can lessen and even cure the behavioral problem. At the same time, however, some behavior problems will not be reversible, and staff should be prepared (and encouraged) to learn to live with their manifestations. In some situations where problem/distressed behavior continues, staff may feel that the behavior poses no threat to the resident's safety, health, or activity pattern and is not disruptive to other residents. For the resident with declining cognitive functions and a behavioral problem, you may wish to consider the following issues:

- Have cognitive skills declined subsequent to initiation of a behavior control program (e.g., psychotropic drugs or physical restraints)?
- Is decline due to the treatment program (e.g., drug toxicity or negative reaction to physical restraints)?
- Have cognitive skills improved subsequent to initiation of a behavior control program?
- Has staff assistance enhanced resident self-performance patterns?

CONCURRENT MEDICAL PROBLEMS

Major Concurrent Medical Problems

Identifying and treating health problems can positively affect cognitive functioning and the resident's quality of life. Effective therapy for congestive heart failure, chronic obstructive pulmonary disease, and constipation can lead, for example, to functional and cognitive improvement. Comfort (pain avoidance) is a paramount goal in controlling both acute and chronic conditions for cognitively impaired residents. Verbal reports from residents should be one (but not the only) source of information. Some residents will be unable to communicate sufficiently to pinpoint their pain.

FAILURE TO THRIVE

Cognitively impaired residents can reach the point where their accumulated health/neurological problems place them at risk of clinical complications (e.g., pressure ulcers) and death. As this level of disability approaches, staff can review the following:

- Do emotional, social, and/or environmental factors play a key role?
- If a resident is not eating, is this due to a reversible mood problem, a basic personality problem, a negative reaction to the physical and interactive environment in which eating activity occurs; or a neurological deficit such as deficiency in swallowing or loss of hand coordination?
- Could an identified problem be remedied through improved staff education -- trying an antidepressant medication, referral to OT for training or an innovative counseling program?
- If causes cannot be identified, what reversible clinical complication can be expected as death approaches (e.g., fecal impaction, UTI, diarrhea, fever, pain, pressure ulcers)?
- What interventions are or could be in place to decrease complications?

FUNCTIONAL LIMITATIONS

Extent and Rate of Change of Resident Functional Abilities

Functional changes are often the first concrete indicators of cognitive decline and suggest the need to identify reversible causes. You may find it helpful to determine the following:

- To what extent is resident dependent for locomotion, dressing and eating?
- Could the resident be more independent?
- Is resident going downhill (e.g., experiencing declines in bladder continence, locomotion, dressing, vision, time involved in activities)?

SENSORY IMPAIRMENTS

Perceptual Difficulties

Many cognitively impaired residents have difficulty identifying small objects, positioning a plate to eat, or positioning the body to sit in a chair. Such difficulties can cause a resident to become cautious and ultimately cease to carry out everyday activities. If problems are vision-based, corrective programs may be effective. Unfortunately, many residents have difficulty indicating that the source of their problem is visual. Thus, the cognitively impaired can often benefit if tested for possible visual deficits.

Ability to Communicate

Many individuals suffering from cognitive deficits seem incapable of meaningful communication. However, many of the seemingly incomprehensible behaviors (e.g., screaming, aggressive behavior) in which these individuals engage may constitute their only form of communication. By observing the behavior and the pattern of its occurrence, one can frequently come to some understanding of the needs of individuals with dementia. For example, residents who are restrained for their own safety may become noisy due to bladder or bowel urgency.

- Is resident willing/able to engage in meaningful communication?
- Does staff use non-verbal communication techniques (e.g., touch, gesture) to encourage resident to respond?

MEDICATIONS

Psychoactive and other medications can be a factor in cognitive decline. If necessary, review Psychotropic Drug Use RAP.

INVOLVEMENT FACTORS

Opportunities for Independent Activity

Staff can encourage residents to participate in the many available activities, and staff can guard against assuming an overly protective attitude toward residents. **Decline in one functional area does not indicate the need for staff to assume full responsibility in that area nor should it be interpreted as an indication of inevitable decline in other areas.** Review information in the MDS when considering the following issues:

- Are there factors that suggest that the resident can be more involved in his/her care (e.g., instances of greater self-performance; desire to do more independently; retained ability to learn; retained control over trunk, limbs, and/or hands)?
- Can resident participate more extensively in decisions about daily life?
- Does resident retain any cognitive ability that permits some decision-making?
- Is resident passive?

- Does resident resist care?
- Are activities broken into manageable subtasks?

Extent of Involvement in Activities of Daily Life

Programs focused on physical aspects of the resident's life can lessen the disruptive symptoms of cognitive decline for some residents. Consider the following:

- Are residents with some cognitive skills and without major behavioral problems involved in the life of the facility and the world around them?
- Can modifying task demands, or the environmental circumstances under which tasks are carried out, be beneficial?
- Are small group programs encouraged?
- Are special environmental stimuli present (e.g., directional markers, special lighting)?
- Does staff regularly assist residents in ways that permit them to maintain or attain their highest predictable level of functioning (e.g., verbal reminders, physical cues and supervision regularly provided to aid in carrying out ADLs; ADL tasks presented in segments to give residents enough time to respond to cues; pleasant, supportive interaction)?
- Has the resident experienced a recent loss of someone close (e.g., death of spouse, change in key direct care staff, recent move to the nursing facility, decreased visiting by family and friends)?

2. COGNITIVE LOSS/DEMENTIA RAP KEY

(For MDS Version 2.0)

TRIGGER – REVISION	GUIDELINES
<p><i>A cognitive loss/dementia problem suggested if one or more of following present:</i></p> <ul style="list-style-type: none"> • Short-Term Memory Problem [B2a = 1] • Long-Term Memory Problem [B2b = 2] • Impaired Decision-Making^(a) [B4 = 1, 2, or 3] • Problem Understanding Others^(b) [C6 = 1, 2, or 3] <p>^(a) Note: Code B4 = 3 also triggers on the ADL (Maintenance) RAP.</p> <p>^(b) Note: These codes also trigger on the Communication RAP.</p>	<p><i>Factors to review for relationship to cognitive loss:</i></p> <ul style="list-style-type: none"> • Neurological – MR/DD Status [AB10], Delirium [B5], Cognitive Decline [B6], Alzheimer's or Other Dementias [I1q, I1u]. <p><i>Confounding problems that may require resolution or suggest reversible causes:</i></p> <ul style="list-style-type: none"> • Mood/Behavior – Depression, Anxiety, Sad Mood or Mood Decline [E1, E2, E3], Behavioral Symptoms or Behavioral Decline [E4, E5], Anxiety Disorder [I1dd], Depression [I1ee], Manic Depressive Disorder [I1ff], Other Psychiatric Disorders [I1gg, J1e, J1i]. • Concurrent Medical Problems – Constipation [H2b], Diarrhea [H2c], Fecal Impaction [H2d], Diabetes [I1a], Hypothyroidism [I1c], CHF [I1f] Other Cardiovascular Disease [I1k], Asthma [I1hh], Emphysema/COPD [I1ii], Cancer [I1pp], UTI [I2j], Pain [J2]. • Failure to Thrive – Terminal Prognosis [J5c], Low Weight for Height [K2a,b], Weight Loss [K3a], Resident Status Deteriorated Since Last Assessment [Q2]. • Functional Limitations – ADL Impairment [G1], ADL Task Segmentation [G7], Decline in ADL [G9], Decline in Continence [H4]. • Sensory Impairment – Hearing Problems [C1], Speech Unclear [C5], Rarely/Never Understands [C6], Visual Problems [D1], Skin Desensitized to Pain/Pressure [M4e]. • Medications – Antipsychotics [O4a], Antianxiety [O4b], Antidepressants [O4c], Diuretics [O4e]. • Involvement Factors – New Admission [AB1], Withdrawal from Activities [E1o], Participates in Small Group Activities [F1f, N3b, record], Staff/Resident Believe Resident Can Do More [G8a,b], Trunk, Limb or Chair Restraint [P4c,d,e].

3. RESIDENT ASSESSMENT PROTOCOL: VISUAL FUNCTION

I. PROBLEM

The aging process leads to a gradual decline in visual acuity: a decreased ability to focus on close objects or to see small print, a reduced capacity to adjust to changes in light and dark, and diminished ability to discriminate color. The aged eye requires about 3-4 times more light in order to see well than the young eye.

The leading causes of visual impairment in the elderly are macular degeneration, cataracts, glaucoma, and diabetic retinopathy. In addition, visual perceptual deficits (impaired perceptions of the relationship of objects in the environment) are common in the nursing facility population. Such deficits are common consequence of cerebrovascular events and are often seen in the late stages of Alzheimer's disease and other dementias. The incidence of all these problems increases with age.

In 1974, 49% of all nursing facility residents were described as being unable to see well enough to read a newspaper with or without glasses. In 1985, over 100,000 nursing facility residents were estimated to have severe visual impairment or no vision at all. Thus vision loss is one the most prevalent losses of residents in nursing facilities. A significant number of residents in any facility may be expected to have difficulty performing tasks dependent on vision as well as problems adjusting to vision loss.

The consequences of vision loss are wide-ranging and can seriously affect physical safety, self-image, and participation in social, personal, self-care, and rehabilitation activities. This RAP is primarily concerned with identifying two types of residents: 1) Those who have treatable conditions that place them at risk of permanent blindness (e.g., Glaucoma: Diabetes, retinal hemorrhage); and 2) those who have impaired vision whose quality of life could be improved through use of appropriate visual appliances. Further, the assumption is made that residents with new acute conditions will have been referred to follow-up as the conditions were identified (e.g., sudden loss of vision; recent red eye; shingles; etc). To the extent that this did not occur, the RAP KEY follow-up questions will cause staff to ask whether or not such a referral should be considered.

II. TRIGGERS

An acute, reversible (R) visual function problem or the potential for visual improvement (I) suggested if one or more of following present:

- Side Vision Problem (*Reverse*)
[D2a = checked]
- Cataracts (*Reverse*)
[I1jj = checked]

- Glaucoma (*Reverse*)
[I111 = **checked**]
- Vision Impaired (*Improve*)
[D1 = 1, 2, 3]

III. GUIDELINES

Visual impairment may be related to many causes, and one purpose of this section is to screen for the presence of major risk factors and to review the resident's recent treatment history. This section also includes items that ask whether the visually impaired resident desires or has a need for increased functional use of eyes.

Eye Medications

Of greatest importance is the review of medications related to glaucoma (phospholine iodide, pilocarpine, propine, epinephrine, Timoptic or other Beta-Blockers, diamox, or Neptazane).

- Is the resident receiving his/her eye medication as ordered?
- Does the resident experience any side effects?

Diabetes, Cataracts, Glaucoma, or Macular Degeneration

Diabetes may affect the eye by causing blood vessels in the retina to hemorrhage (retinopathy). All these conditions are associated with decreased visual acuity and visual field deficits. If resident is able to cooperate it is very possible to test for glaucoma and retinal problems.

Exam by Ophthalmologist or Optometrist Since Problem Noted

- Has the resident been seen by a consultant?
- Have the recommendations been followed (e.g. medications, refraction [new glasses], surgery)?
- Is the recommendation compatible with the resident's wishes (e.g., medical rehab. vs. surgery)?

If Neurological Diagnosis or Dementia Exam by Physician Since Problem Noted

Check the medical record to see if a physician has examined the resident for visual/perceptual difficulties. Some residents with diseases such as myasthenia gravis, stroke, and dementia will have such difficulties associated with central nervous system in the absence of diseases of the eye.

Sad or Anxious Mood

Some residents, especially those in a new environment, will complain of visual difficulties. Visual disorganization may improve with treatment of the sad or anxious mood.

Appropriate Use of Visual Appliances

Residents may have more severe visual impairment when they do not use their eyeglasses. Residents who wear reading glasses when walking, for example, may misperceive their environment and bump into objects or fall.

- Are glasses labelled or color-coded in a fashion that enables the resident/staff to determine when they should be used?
- Are the lenses of glasses clean and free of scratches?
- Were glasses recently lost? Were they being recently used, and now they are missing?

Functional Need for Eye Exam/New Glasses

Many residents with limited vision will be able to use the environment with little or no difficulty, and neither the resident nor staff will perceive the need for new visual appliances. In other circumstances, needs will be identified, and for residents who are capable of participating in a visual exam, new appliances, surgery to remove cataracts, etc., can be considered.

- Does resident have peripheral vision or other visual problem that impedes his/her ability to eat food, walk on the unit, or interact with others?
- Is residents's ability to recognize staff limited by a visual problem?
- If resident is having difficulty negotiating his environment or participating in self-care activities because of visual impairment has he/she been referred to low vision services?
- Does resident report difficulty seeing TV/reading material of interest?
- Does resident express interest in improved vision?
- Has resident refused to have eyes examined? How long ago did this occur? Has it occurred more than once?

Environmental Modifications

Residents whose vision cannot be improved by refraction, or medical and/or surgical intervention may benefit from environmental modifications.

- Does the resident's environment enable maximum visual function (e.g., low-glare floors and table surfaces, night lights)?
- Has the environment been adapted to resident's individual needs (e.g., large print signs marking room, color coded tape on dresser drawers, large numbers on telephone, reading lamp with 300 watt bulb)? Could the resident be more independent with different visual cues (e.g., labeling items, task segmentation) or other sensory cues (e.g., cane for recognizing there are objects in path)?

Acute Problems that May Have Been Missed: Eye Pain, Blurry Vision, Double Vision, or Sudden Loss of Vision

These symptoms are usually associated with acute eye problems.

- Has resident been evaluated by a physician or ophthalmologist?

Residents with communication impairments may be very difficult to assess. Residents who are unable to understand others may have problems following the directions necessary to test visual acuity.

3. VISUAL FUNCTION RAP KEY

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TRIGGER – REVISION	GUIDELINES
<p><i>An acute, reversible visual function problem or the potential for visual improvement suggested if one or more of following present:</i></p> <ul style="list-style-type: none"> • Side Vision Problem (<i>Reverse</i>) [D2a = checked] • Cataracts (<i>Reverse</i>) [I1jj = checked] • Glaucoma (<i>Reverse</i>) [I1ll = checked] • Vision Impaired (<i>Improve</i>) [D1 = 1, 2, 3] 	<p><i>Issues and problems to be reviewed that may suggest need for intervention:</i></p> <ul style="list-style-type: none"> • Eye Medications [from record]. • Diabetes [I1a], Cataracts [I1jj], Glaucoma [I1ll], Macular Degeneration [I1mm]. • Exam by Ophthalmologist Since Problem Noted [from record]. • Neurological Diagnosis or Dementia [I1q to I1cc]. • Indicators of Depression, Anxiety, Sad Mood [E1]. • Appropriate Use of Visual Appliances [D3; from record observation]. • Functional Need for Eye Exam/New Glasses [from observation]. • Environmental Modifications [from record, observation]. • Other Acute Problems: Eye Pain, Blurry Vision, Double Vision, Sudden Loss of Vision [from record, observation].